H. B. 4217

(By Delegates Perdue, Fleischauer, Campbell, Ellington, Morgan and Stephens)

[Introduced January 17, 2014; referred to the Committee on Health and Human Resources.]

A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a two new sections, designated §9-5-22 and §9-5-23, all relating to Medicaid; requiring the Bureau of Medical Services to submit an annual report to the Legislature; requiring certain information to be included in the report; requiring website publication of certain information.

Be it enacted by the Legislature of West Virginia:

That the Code of West Virginia, 1931, as amended, be amended by adding thereto two new sections, designated §9-5-22 and §9-5-23, all to read as follows:

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§**9-5-22. Medicaid managed care reporting.**

(a) Beginning January 1, 2016, and annually thereafter, the Bureau for Medical Services shall submit an annual report to the

Legislative Oversight Commission on Health and Human Resources Accountability that includes, but is not limited to, the following information:

(1) The name and geographic service area of each managed care network that has contracted with the Department of Health and Human Resources.

(2) The total number of health care providers in each managed care network broken down by provider type and specialty and by each geographic service area.

(3) The monthly average and total of the number of members enrolled in each network broken down by eligibility group.

(4) The percentage of primary care practices that provide verified continuous phone access with the ability to speak with a primary care provider clinician within thirty minutes of member contact for each managed care network.

(5) The percentage of regular and expedited service authorization requests processed within the time frames specified by the contract for each managed care network.

(6) The percentage of claims paid for each provider type within thirty calendar days and the average number of days to pay all claims for each managed care network.

(7) The number of claims denied or reduced by each managed care network for each of the following reasons:

(A) Lack of documentation to support medical necessity;

(B) Prior authorization was not on file;

(C) Member has other insurance that must be billed first;

(D) Claim was submitted after the filing deadline;

(E) Service was not covered by the managed care network; and

(F) Due to process, procedure, notification, referrals, or any other required administrative function of a managed care network.

(8) The number and dollar value of all claims paid to nonnetwork providers by claim type categorized by emergency services and nonemergency services for each managed care network by geographic service area.

(9) The number of members choosing the managed care network and the number of members auto-enrolled into each managed care network, broken down by managed care network.

(10) The amount of the average per member per month payment and total payments paid to each managed care network.

(11) The medical loss ratio of each managed care network and the amount of any refund to the state for failure to maintain the required Medical Loss Ratio.

(12) A comparison of health outcomes, which includes, but is not limited to, the following outcomes among each managed care network:

(A) Adult asthma admission rate;

(B) Congestive heart failure admission rate;

(C) Uncontrolled diabetes admission rate;

(D) Adult access to preventative/ambulatory health services;

(E) Breast cancer screening rate;

(F) Well child visits; and

(G) Childhood immunization rates.

(13) A copy of the member and provider satisfaction survey report for each managed care network.

(14) A copy of the annual audited financial statements for each managed care network.

(15) The total amount of savings to the state for each shared savings managed care network.

(16) A brief factual narrative of any sanctions levied by the Department of Health and Human Resources against a managed care network.

(17) The number of members, broken down by each managed care network, filing a grievance or appeal and the number of members who accessed the state fair hearing process and the total number and percentage of grievances or appeals that reversed or otherwise resolved a decision in favor of the member.

(18) The number of members receiving unduplicated Medicaid services from each managed care network, broken down by provider type, specialty, and place of service.

(19) The number of members receiving unduplicated outpatient emergency services, broken down by managed care network and aggregated by the following hospital classifications:

(A) State;

(B) Public nonstate nonrural;

(C) Rural; and

(D) Private.

(20) The number of total inpatient Medicaid days broken down by managed care network and aggregated by the following hospital classifications:

(A) State;

(B) Public nonstate nonrural;

(C) Rural; and

(D) Private.

(21) The number of claims for emergency services, broken out by managed care network, whether the claim was paid or denied and by provider type. The initial report shall include comparable metrics for claims for emergency services that were processed by the Medicaid fiscal intermediary for the period, either calendar or state fiscal year, prior to the date of services initially being provided.

(22) The following information concerning pharmacy benefits broken down by each managed care network and by month:

(A) Total number of prescription claims;

(B) Total number of prescription claims subject to prior authorization;

(C) Total number of prescription claims denied; and

(D) Total number of prescription claims subject to step-therapy or fail first protocols.

(23) Any other metric or measure which the Bureau of Medical Services deems appropriate for inclusion in the report.

§9-5-23. Bureau of Medical Services information.

(a) The Bureau of Medical Services shall publish all informational bulletins, health plan advisories, and guidance published by the department concerning the Medicaid program on the department's website.

(b) The Bureau of Medical Services shall publish all Medicaid state plan amendments and any related correspondence within twenty-four hours of receipt of the correspondence submission to the Centers for Medicare and Medicaid Services.

(c) The Bureau of Medical Services shall publish all formal responses by the Centers for Medicare and Medicaid Services regarding any state plan amendment on the department's website within twenty-four hours of receipt of the correspondence.

NOTE: The purpose of this bill is require an annual report containing information about Medicaid managed care be provided to the Legislative Oversight Commission on Health and Human Resources.

Both sections are new; therefore, they have been completely underscored.